INDIGENT DEFENSE MISCELLANEOUS FEE CLAIM FORM

1. CHECK THE BOX INDICATING THE TYPE OF CLAIM:

ÿ CERTIFIED SHORTHAND REPORTER ÿ INVESTIGATOR ÿ EVALUATION

ÿ EXPERT WITNESS ÿ INTERPRETER _____
(LANGUAGE)

ÿ OTHER (EXPLAIN):

2. CASE INFORMATION:

COUNTY:	COURT NUMBER:
COURT APPOINTED ATTORNEY:	
TITLE OF CASE:	
CLIENT'S FULL NAME:	

3. CLAIM INFORMATION:

CERTIFIED SHORTHAND REPORTER: DATE ORDERED ____/____/____ DATE DELIVERED____/____/

ALL OTHER CLAIM TYPES: DATE SERVICES BEGAN ____/____/____ DATE SERVICES ENDED ____/____/

CLAIM TOTAL: $

4. APPROVAL: _____ **CLAIM TOTAL: $**
STATE PUBLIC DEFENDER **(if changed)**

5. CLAIMANT INFORMATION: ÿ **Change of Information**

NAME:			EMAIL:
ADDRESS:			PHONE:
CITY:	STATE:	ZIP:	FAX:
SS # OR FEDERAL ID #:		ARE YOU A STATE EMPLOYEE? ÿ YES ÿ NO	

6. CERTIFICATION: I, THE UNDERSIGNED, CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

DATE: / /	**CLAIMANT SIGNATURE:**

(10-09-03)

~ INSTRUCTIONS FOR COMPLETING MISCELLANEOUS FEE CLAIM FORM ~

1. **Put a check mark in the box to indicate the type of claim you are submitting.**

2. **Case Information**
   County: Enter the name of the county in which the appointment originated.
   Court Number: Enter the court's case number
   Court Appointed Attorney: Enter the name of the attorney that is court appointed on this case.
   Title of Case: Enter the entire case name.
   Client's Full Name: Enter the client's first and last name.

3. **Claim Information**
   Certified Shorthand Reporter: If this claim is for a deposition or transcript enter the date the deposition or transcript was ordered and the date the deposition or transcript was delivered.
   All Other Claim Types: If this claim is for any other type of claim other than for a deposition or transcript, enter the date services began and the date services ended.
   Claim Total: Enter the total amount of your claim here.

4. **Approval and Claim Total:** This area is for use by the state public defender only.

5. **Claimant Information:** Enter the name, address, e-mail, phone, fax, and social security number or federal identification number of the person or firm payment should be made to. If any of this information is different than prior claims, check the "change of information" box.

6. **Certification:**
   Date: Indicate the date on which the claim was signed.
   Signature: The claimant must sign the form. If the claim is to be paid under a social security number, that person must sign the claim. If a federal identification number is used, any partner may sign the claim.

Mailing: Mail the original and one copy of the claim form, along with one set of attachments to:

State Public Defender
Miscellaneous Claims
Fourth Floor, Lucas Building
321 East 12th Street
Des Moines, Iowa 50319-0087

Questions: If you have questions about reimbursement or completing this form you may call (515) 242-6158 or e-mail claims@spd.state.ia.us.